Plan of Care for Health Assistant Services

Student's Name: _____ _____ _____
Last First School
DOB: _____ Medicaid/FAMIS # _____ Grade____ IEP Date_____

ICD 9 Code _____

Medical Condition:

_____
_____

Goals and Objectives:

_____
_____
_____

Treatment and Procedures Required:

_____
_____

Medications/Treatment and Procedures:

Date	Medication/Treatment or Procedure	Dose	Frequency	Discontinue	Comment

Prescriber: _____ Date of Implementation of POC: _____

Type of Assistance: ____ Nursing ____OT ____ PT ____ SLP

_____ _____ _____
Name Signature Date

_____ _____ _____
Name Signature Date

(Must be professional of the healing arts such as a licensed OT, PT, RN or SLP; ASHA certified or licensed by the Board of Audiology and SLP in the discipline that the assistance is taking place)

Forward to : _____
Primary Care Physician
Physician is not required to sign this form

Med 11/R10/03